

A black and white photograph of wheat stalks, with the heads of the wheat in sharp focus against a blurred background of more stalks and a bright sky. The stalks are arranged vertically, creating a sense of height and growth.

South Dakota

*Strategy for
Suicide Prevention*

Suicide Prevention is Everyone's Business

January 2005

South Dakota Strategy for Suicide Prevention

JANUARY 2005

Prepared by

The Front Porch Coalition, Rapid City, 605-348-6692

The HELP!Line Center, Sioux Falls, 605-339-4357

In partnership with

S.D. Department of Health, Pierre, 605-773-3361

S.D. Department of Human Services, Pierre, 605-773-5990

The SDSSP is in the public domain. It is not intended for commercial use. Any duplication or distribution of its contents should accurately represent the original, and both the SDSSP and other sources should be credited.

Suggested citation:

"South Dakota Strategy for Suicide Prevention." Pierre: S.D. Departments of Health and Human Services, 2005.

S.D. STRATEGY FOR SUICIDE PREVENTION

CONTENTS

SDSSP Workgroup	1
Introductory Letters	3
■ Sen. Arlene Ham-Burr	
■ S.D. Secretary of Health Doneen Hollingsworth & S.D. Secretary of Human Services Betty Oldenkamp	
Preface	5
Suicide Prevalence and Prevention.....	8
Overview	8
Suicide in the United States.....	10
Suicide in South Dakota.....	14
Nonfatal Suicidal Behavior.....	20
A Public Health Response to Suicide	21
Mental Health Care and Addiction Recovery Services.....	25
Survivors of a Loved One’s Suicide	31
Community Suicide Prevention Toolkit	33
Conclusion	34
Goals, Objectives, Action Steps	36
Appendix A: Senate Concurrent Resolution No. 5.....	42
Appendix B: Suicide Prevention Dictionary	45
Appendix C: Resources	52

SDSSP WORKGROUP

Facilitators

- Franklin Cook, Executive Director, Front Porch Coalition, Rapid City
- Janet Kittams-Lalley, Services & Clinical Director, HELP!Line Center, Sioux Falls

Members

- Randy Allen, Clinical Director, Behavioral Management Systems, Rapid City
- Jaci Casanova-Keller, Adult Services and Aging, S.D. Department of Social Services, Pierre
- Sally Damm, Administrator, United Retirement Center, Brookings
- Teton Ducheneaux, Mental Health Director, Cheyenne River Sioux Tribe Wellness Center, Eagle Butte
- Terry Dosch, Executive Director, S.D. Council of Community Mental Health Centers, Pierre
- Sandy Fox, Emergency Department Manager, Avera McKennan Hospital, Sioux Falls
- Dr. Mark Garry, Mental Health Director, Sioux San Hospital, Rapid City
- Paula Hallberg, Director of State Affairs, Community Healthcare Association of the Dakotas, Sioux Falls
- Sen. Arlene Ham-Burr, S.D. Legislature, District 32, Rapid City
- Mel Harrington, Sioux Falls Area Director, Lutheran Social Services, Sioux Falls
- Ethleen Iron Cloud-Two Dogs, Program Director–Principal Investigator, Nagi Kicopi, Wakanyeja Pawicayapi, Porcupine
- Jim Kinyon, Executive Director, Catholic Social Services, Rapid City
- Gayle Kocer, Executive Director, Badlands Resource Conservation & Development District, Martin
- Diana Larson, Counselor, Madison High School, Madison
- Kira LeCompte, Mental Health Program Specialist, Indian Health Services Aberdeen Area Office, Aberdeen
- Mike Leidholt, Sheriff, Hughes County, Pierre
- Holly LeMay, Board Member, Rapid City Area Schools, Rapid City
- Steve Lindquist, Director, Avera McKennan Behavioral Health Services, Sioux Falls
- Linda Lodmel, Survivor Support Group Leader, Heartbeat, Huron
- Kim Malsam-Rysdon, Director, Division of Mental Health, S.D. Department of Human Services, Pierre

- Amy Marsh, Program Coordinator, S.D. Emergency Medical Services for Children, Sioux Falls
- Colleen Miller, Director, Sioux Valley Behavioral Health, Sioux Falls
- Marcie Moran, Sowing Seeds of Hope, Sioux Falls
- Rev. Tom Opoien, Pastor, Lutheran Memorial Church, Pierre
- Sandy Parham, Suicide Prevention Specialist, HELP!Line Center, Sioux Falls
- Noelle Phillips, Counselor, Rapid City Regional Hospital—Center for Behavioral Health, Rapid City
- Carol Posthumus, School Nurse, Rapid City Area Schools, Rapid City
- Janet Ricketts, Director, Coordinated School Health Program, S.D. Department of Education and Cultural Affairs, Pierre
- Capt. Bob Runyon, Sioux Falls Police Department, Sioux Falls
- Tony Sieler, Chairman, Mitchell School Board, Mitchell
- Gib Sudbeck, Director, Division of Alcohol and Drug Abuse, S.D. Department of Human Services, Pierre
- Kayla Tinker, Director, Office of Family Health, S.D. Department of Health, Pierre
- Beth Todd-Bazemore, Department of Psychology, University of South Dakota, Vermillion
- Ted Weiland, Weiland Funeral Chapel, Madison
- Denise White, Adolescent Health Coordinator, S.D. Department of Health, Pierre
- Rev. Dave Zellmer, Pastor, Lutheran Memorial Church, Pierre

I am not influenced by the expectation of promotion or pecuniary reward. I wish to be useful, and every kind of service necessary for the public good becomes honorable by being necessary.

— Nathan Hale, American patriot

An Open Letter

By Sen. Arlene Ham-Burr

Dear Fellow South Dakotans:

Life is so precious, and suicide is not an option in most people's minds. But for those that it is, it must be a terrible state of mind to be in. Each day is a battle for people who suffer with mental illness or drug and alcohol abuse—or who feel hopeless. Most of us don't know about the daily struggle they fight. We think it will never happen to us, to our family, or to anyone we love. Let me tell you that it can, as I painfully learned when my husband, Don Ham, took his life. Let's find a way to prevent suicide rather than hide it.

It is difficult for people to talk about suicide because it is so unacceptable in our society, and many victims don't tell family or friends that they're in trouble. In my husband's case, he talked about it and attempted several times before he died by suicide. And, sadly, the last time when he told me about his intentions, I didn't hear him. It was so obvious, after the fact, but at the time it did not register. I had to learn after Don died that it's not the victim's fault, but it's not the survivor's fault either.

We need the South Dakota Strategy for Suicide Prevention, so there can be prevention programs in every community. Sometimes suicide is like an epidemic, and having preventive programs in place can stem the tragic loss of one life after another. The more we fight stigma and make it possible for people to talk about suicide, the more people will be able to tell us that they have had serious thoughts about taking their lives. Then we can help.

After my husband's death, because it was so public, I was amazed at the number of people who talked to me about someone in their family who had died by suicide but it was never made public or discussed. One woman told me her brother had taken his life 52 years ago but she had never discussed it with anyone. More than a few people have told me how they had planned their demise. Among all of the answers I got about why they had been suicidal, the most vivid explanation I got was from a man who said it felt like he was in a hole and there was no way to get out. He was a very successful businessman, but he said he felt out of control—and had lost all hope.

When I first became a volunteer with the mental health association 40 years ago, mental illness was a secret and as unacceptable to society then as suicide is today. More education and public awareness have begun to decrease the stigma so people can tell someone they are depressed or have anxiety, and the word is getting out that depression is a treatable disease. Depression is not about a weak character, poor parenting, or failure—and help is available for it. The same is true for a person who is considering taking his or her life, but much more can be done to prevent suicide.

This statewide strategy will work if it is implemented through projects that are supported by each community in South Dakota. Together, we can make a real difference—and we can save people's lives.

**DEPARTMENT OF HUMAN SERVICES**

OFFICE OF THE SECRETARY
Hillsview Properties Plaza, East Highway 34
c/o 500 East Capitol
Pierre, South Dakota 57501-5070
Phone: (605) 773-5990
FAX: (605) 773-5483
TTY: (605) 773-5990
www.state.sd.us/dhs

DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
Phone: (605) 773-3361
Fax: (605) 773-5683
www.state.sd.us/doh/

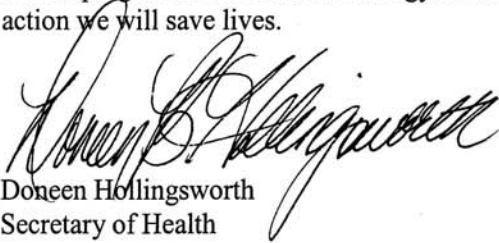
January 19, 2005


Suicide is a serious concern for our nation and for our state. In 2003 alone, 103 South Dakotans died by suicide. Since 1990, we've lost more than 1400 lives to suicide. The South Dakota Strategy for Suicide Prevention represents an important starting point for the prevention of suicide attempts and completions.

The South Dakota Strategy for Suicide Prevention is modeled after the National Strategy for Suicide Prevention and was developed by a workgroup that includes survivors of suicide, state agencies, health care professionals, school personnel, mental health care providers, suicide prevention agencies, and others. This public - private partnership was important in the creation of the strategy and future collaboration will be critical for its successful implementation.

At its core, the strategy recognizes the critical role South Dakota communities play in the prevention of suicide. Combined with efforts to raise awareness and train South Dakotans throughout the state, we know local communities can be effective at preventing suicide. Suicide prevention is truly the responsibility of all of us.

Working in partnership with communities and interested parties in the state, we are confident we can prevent the unnecessary loss of our family members, friends and neighbors. Developing the South Dakota Strategy for Suicide Prevention is the beginning point; through action we will save lives.


Doneen Hollingsworth
Secretary of Health


Betty Oldenkamp
Secretary of Human Services

PREFACE

By Franklin Cook and Janet Kittams-Lalley

The development of the South Dakota Strategy for Suicide Prevention began in Chamberlain in June 2002 when the two of us, representing the Front Porch Coalition and the HELP!Line Center, met informally with Denise White, then Adolescent Health Coordinator for the S.D. Department of Health, to explore how the National Strategy for Suicide Prevention (NSSP) might be implemented in South Dakota. Afterward, a group of stakeholders was invited to a gathering set for November 2002, where the NSSP was introduced, comprehensive data on suicide in South Dakota were presented, and those in attendance were asked if they would be interested in forming an ad hoc, public-private body to develop the South Dakota Strategy for Suicide Prevention (SDSSP). That group, and those who joined it as the process unfolded, became the SDSSP Workgroup. We are deeply grateful to each Workgroup member for their contributions to setting suicide prevention apart in South Dakota as a public health problem that merits a vigorous, comprehensive, statewide solution.

Between November 2002 and a meeting in May 2004, the Workgroup met numerous times in Pierre, Sioux Falls, and Chamberlain and also worked remotely through the Dakota Digital Network, e-mail, and conference calls. Judith Kahn of the Konopka Institute, University of Minnesota, facilitated the main sessions where the goals and objectives were formulated. In October 2003, 10 members of the Workgroup received technical assistance on the development of the SDSSP at a conference in Denver, Colo., supported by the Suicide Prevention Resource Center, Newton, Mass., and the Region VIII office of the Public Health Service, Denver (SPRC and PHS Region VIII staff also provided technical assistance for a key Workgroup session in Sioux Falls in June 2003).

Although we organized, revised, and edited the final document, the South Dakota Strategy for Suicide Prevention reflects the substance and the spirit of those meetings, and the Workgroup is its author.

In early 2003—during the 78th Legislative Session of the South Dakota Legislature—Senate Concurrent Resolution 5, sponsored by Sen. Arlene Ham-Burr and Rep. Stan Adelstein and co-sponsored by 27 additional legislators, unanimously passed both houses of the legislature (see Appendix A, page 42). It declares that “the prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem” and supports “the creation of a South Dakota plan

for suicide prevention that will lay the groundwork for suicide prevention efforts ... designed specifically for use in South Dakota communities.” The work of the legislature endowed the SDSSP Workgroup’s efforts with the authority that comes from the consent of representative government, and we appreciate the vision of the resolution’s sponsors and the support of the members of the South Dakota Senate and House.

Another key advance came in July 2003 when we met with South Dakota’s Secretary of the Department of Health, Doneen Hollingsworth, and Secretary of the Department of Human Services, Betty Oldenkamp. In the ensuing months, their leadership and commitment of resources—and the diligent work of their staffs—strengthened the SDSSP Workgroup’s capabilities and the power of its collective voice. Without their help, the South Dakota Strategy for Suicide Prevention would not be where it is today—positioned for implementation to begin—and we sincerely thank them.

Except for the federal funds that backed technical assistance for the Workgroup, the funding for the creation of the SDSSP came from the South Dakota Departments of Health and Human Services, a grant from Eli Lilly, and private donations supporting the HELP!Line Center and the Front Porch Coalition. The Workgroup was never officially organized or authorized or supervised by a government entity or anyone else, and it remained autonomous throughout the development of the SDSSP—with all of its members volunteering their time and their agencies’ resources to the effort. The energy for the creation of the SDSSP truly came from those who directly represent people who have been affected by suicide or who are working to prevent suicide, and the South Dakota Strategy for Suicide Prevention belongs not to the state or to any other entity or interest group, but instead to the people of South Dakota.

Most importantly, this document is not by any means the final word on suicide prevention in our state. The South Dakota Strategy for Suicide Prevention is designed as a catalyst and as a starting point from which to mount a fresh attack against what is arguably an epidemic of suicide in our communities. And its success at saving lives depends on how it is implemented, evaluated, funded, and improved year after year in accordance with the wishes and the will of all South Dakotans—for, indeed, suicide prevention is everyone’s business.

"Suicide has stolen lives around the world and across centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."

—National Strategy for Suicide Prevention¹

"Suicide is ultimately a private act. It is difficult to put into words the suffering and agonized state of mind of those who kill themselves ... A minority of those who kill themselves actually write suicide notes, and these only infrequently try to communicate the complex reasons for the act. Still, some consistent psychological themes emerge. Clearest of these is the presence of an unendurable heartache, captured in the simple phrase, 'I can't stand the pain any longer.'"

—Reducing Suicide: A National Imperative²

"Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves. Many Americans are unaware of suicide's toll and its global impact. It is the leading cause of violent deaths worldwide, outnumbering homicide or war-related deaths³ ... The Commission urges swiftly implementing and enhancing the National Strategy for Suicide Prevention to serve as a blueprint for communities and all levels of government."

—President's New Freedom Commission on Mental Health⁴

1. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. (NSSP) Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, 2001, 17.

2. *Reducing Suicide: A National Imperative*. Washington, D.C.: Institute of Medicine, 2002, 17-18.

3. *World Report on Violence and Health*. Geneva: World Health Organization, 2002.

4. *New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Rockville, Md.: U.S. Department of Health and Human Services, 2003.

The mission of the South Dakota Strategy for Suicide Prevention is to reduce suicide attempts and completions throughout South Dakota.

SUICIDE PREVALENCE AND PREVENTION

OVERVIEW

The three documents quoted on the facing page guide a fledgling national suicide prevention movement that was born at the Reno Conference in 1998.⁵ That conference brought together several hundred suicide prevention stakeholders and advocates⁶ from across the country who hoped to ignite a vigorous response to one of the country's most stubborn and misunderstood killers. That movement has been growing since 1998, and is now beginning to systematically help communities across the nation implement "the knowledge and tools ... to save many lives." The South Dakota Strategy for Suicide Prevention (SDSSP) is designed to guide the implementation of life-saving initiatives in South Dakota communities.

The SDSSP is not a set of directives being handed down from a centralized authority to dictate how a public health response to suicide prevention is going to be implemented in South Dakota's communities. Rather, it recommends a framework (in the form of goals and objectives) and a number of initial statewide activities (one or more action steps for each objective). Those goals, objectives, and action steps are detailed beginning on page 36. Taking action in the recommended manner on each of the objectives is designed to initiate improving the necessary infrastructure, support services, technical assistance, training, and programming for full implementation of the state strategy at the community level.

It is hoped that each individual South Dakota community will itself manage the implementation of the SDSSP to benefit its residents. That work will be guided by the South Dakota Community Toolkit for Suicide Prevention (see Goal 1 of the SDSSP, page 36). Technical

5. The Reno Conference resulted in the Surgeon General's release of the "Call to Action to Prevent Suicide" in July 1999 ("The Surgeon General's Call to Action to Prevent Suicide." Washington, D.C.: U.S. Public Health Service, 1999). The "Call to Action" introduced a blueprint for addressing suicide—Awareness, Intervention, and Methodology, or AIM—an approach derived from the collaborative deliberations of the conference participants. The recommendations and their supporting conceptual framework were the precursor to the National Strategy for Suicide Prevention.

6. Those present at Reno included clinicians in the fields of health, mental health, and substance abuse, grassroots advocates, survivors of a loved one's suicide, survivors of a suicide attempt, federal agency representatives, policy makers, researchers, public health specialists, and community leaders.

S.D. Strategy for Suicide Prevention: Goals and Objectives for Action

GOAL 1: Maintain a South Dakota Community Toolkit for Suicide Prevention that guides the development and implementation of suicide prevention programs and training.

GOAL 2: Promote strategies to educate the public as well as community and industry leaders that suicide is a public health problem that is preventable.

GOAL 3: Develop and promote effective clinical and professional practices.

GOAL 4: Improve access to and community linkages among primary care, mental health, and substance abuse services.

GOAL 5: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the media.

GOAL 6: Reduce the danger of lethal means and methods of self-harm.

GOAL 7: Improve and expand surveillance systems.

GOAL 8: Improve services to people who have been affected by the death of a loved one by suicide.

"We want to give the message to the authorities and the public that suicide is not inevitable, and that those who are suicidal do not inevitably commit suicide. The vast majority of suicidal people do not want to die: They just don't want to live under the conditions in which they have to live. We can do a lot. And this [prevention] isn't just for doctors—this is for the conscientious citizen."

— Lars Mehlum, President
International Association for Suicide Prevention⁷

7. Quoted in an article by The Associated Press, Sept. 8, 2004.

assistance is presently available to communities from the national Suicide Prevention Resource Center⁸ (SPRC). In addition, SDSSP Objective 1.1 (see page 36) calls for development of a statewide suicide prevention clearinghouse in South Dakota.⁹ This “first edition” of the SDSSP lays the groundwork for developing the methodology and resources (Community Toolkit and statewide clearinghouse) necessary to initiate a public health response to suicide in South Dakota, but it represents only a beginning. The effectiveness of the SDSSP must be reviewed periodically, and the strategy must evolve methodically in response to the progress being made and to the changing circumstances of suicidal behavior in South Dakota (see Objective 7.1, page 40). Full and ongoing implementation of the SDSSP requires a clear commitment from the people of South Dakota to ensure that the funding, policies, and leadership are in place to accomplish the strategy’s mission, *to reduce suicide attempts and completions throughout South Dakota*.

SUICIDE IN THE UNITED STATES¹⁰

About 30,000 people die of suicide each year in the United States, nearly 85 per day, one death every 18 minutes. In 2002 (the latest year for which national death statistics are available), 31,655 people died by suicide, more than one-and-a-half times as many as died by homicide (there were 17,638 murders in the nation in 2002). Suicide is the 11th leading cause of death in the United States.

The prevalence of suicide in several populations is notably higher than for the country as a whole (in 2002, the national suicide rate was 11.0 per 100,000 people):¹¹

- Men account for 80 percent of suicide deaths in the United States. The death rate for men in 2002 was 17.9 and for women it was 4.3.

8. Suicide Prevention Resource Center; Education Development Center; 55 Chapel Street; Newton, MA 02458-1060; 877-GET-SPRC (438-7772); TTY 617-964-5448; <http://www.sprc.org>; info@sprc.org.

9. The South Dakota suicide prevention clearinghouse has not yet been funded or developed.

10. Except where otherwise noted, the statistics and conclusions about suicide in the United States summarized in this section are based on the American Association of Suicidology’s “Some Facts about Suicide in the U.S.A.,” available online at <http://www.suicidology.org/associations/1045/files/SomeFacts.pdf>; the American Foundation for Suicide Prevention’s “Facts about Suicide,” <http://www.afsp.org/about/factsaboutsuiicide.htm>; and WISQARS (Web-based Injury Statistics Query and Reporting System), maintained by the U.S. Centers for Disease Control’s National Center for Injury Prevention and Control and available at <http://www.cdc.gov/ncipc/wisqars>.

11. Deaths are measured per 100,000 population so the prevalence of a cause of death in any group of people can be compared directly with its prevalence in any other group, for instance, among a sparsely populated area (South Dakota, where the suicide rate was 12.4 per 100,000 people in 2002) and a densely populated area (California, where the suicide rate was 9.2 per 100,000 in 2002) and the larger population that contains them (United States, where the suicide rate was 11.0 in 2002). Source — *Deaths: Final data for 2002. National Vital Statistics Reports*.

- Whites account for 90 percent of suicides.¹²
- White men over 50 years old make up less than 25 percent of the population but account for 40 percent of all suicides.
- Suicide rates among elderly men rise significantly after 65 and increase continually the older they are. At 65 men's suicide rate in 2002 was 21.9, at 70 it was 27.9, at 75 it was 34.3, at 80 it was 44.1, and at 85 and older it was 51.1.
- Suicide is the third-leading cause of death among the country's youth and young adults, age 15–24.
- While the overall suicide rate for Native Americans as a whole, 10.5 in 2002, was slightly lower than that of whites, 12.2, the rate for Native American males 15–19 was almost twice as high, 22.8, as it was for white males of the same age, 13.4. (There are large variations in suicide rates among different tribal groups.)

While focusing on specific populations points out that suicide is clearly a serious problem in identifiable subgroups of people in the United States, it is also abundantly clear that death by suicide is taking lives in large numbers throughout the population, in all age groups except very young children. The table "U.S. Suicides in 2002 across the Lifespan" shows that the rates and number of deaths begin to climb in the mid-teen years, 15–19, and continue to increase steadily through adulthood, 20–49, then both the number of deaths and the suicide rates decrease among the elderly, 60–69, but finally the rates increase again among those 70 and older (the number of suicide deaths decreases by comparison because older people are dying of many different causes besides suicide).

12. Kochanek, K.D., Murphy, S.L., Anderson, R.N., and Scott, C. *Deaths: Final data for 2002. National Vital Statistics Reports*, 53(5). Hyattsville, Md.: National Center for Health Statistics, 2004. Summary available at <http://mypage.iusb.edu/~jmcintos/usa2002summary.htm>.

U.S. SUICIDES IN 2002 ACROSS THE LIFESPAN		
Age	Deaths	Rate
5-9	4	0.0
10-14	260	1.2
15-19	1513	7.4
20-24	2497	12.2
25-29	2423	12.8
30-34	2623	12.6
35-39	3141	14.4
40-44	3710	16.2
45-49	3473	16.3
50-54	2835	15.1
55-59	2186	14.6
60-64	1432	12.3
65-69	1197	12.5
70-74	1266	14.5
75-79	1231	16.6
80-84	1028	19.4
85+	826	18.1
Source – WISQARS (http://www.cdc.gov/ncipc/wisqars)		

SOUTH DAKOTA COUNTIES SUICIDE DEATH RATES — 1980–2001

(Figures are deaths per 100,000 population)

COUNTY	DEATH RATE
Buffalo	49.2
Dewey	30.3
Ziebach	30.2
Fall River	29.4
Mellette	27.4
Todd	27.4
Shannon	26.4
Clark	25.3
McCook	24.6
Sanborn	23.1
Brule	20.4
Hyde	19.9
Potter	19.5
Lawrence	19.2
Campbell	18.7
Aurora	18.7
Charles Mix	18.3
Miner	18.2
Roberts	17.6
Hamlin	17.2
Corson	17.1
Butte	16.8
Tripp	16.3
Jackson	16.3
Faulk	16.2
Hughes	16.2
Meade	15.7
Marshall	15.5
Lyman	14.7
Bennett	14.7
Pennington	14.0
Stanley	13.7
Day	13.7
S.D.	13.5

COUNTY	DEATH RATE
Yankton	13.4
Grant	13.4
Codington	13.1
Walworth	12.8
Beadle	12.6
Jones	12.0
Davison	11.9
Custer	11.8
Deuel	11.6
Minnehaha	11.6
Lake	11.4
Perkins	11.3
Gregory	10.9
Haakon	10.8
Brown	10.5
Spink	10.2
Clay	10.2
Moody	10.1
Bon Homme	9.8
Kingsbury	9.8
Hutchinson	8.8
Turner	8.6
Brookings	7.8
Lincoln	7.7
Hanson	7.6
Union	7.6
McPherson	7.3
Douglas	6.9
Sully	6.1
Edmunds	5.5
Hand	5.1
Jerauld	4.1
Harding	0.0

Source — S.D. Department of Health

SUICIDE IN SOUTH DAKOTA¹³

Every three or four days in South Dakota, someone dies by suicide. Two people die every week, eight die every month—more than a thousand die by suicide every decade. To be precise, 1,068 people completed suicide in the 10-year period 1993–2002 (an average of 107 deaths per year).

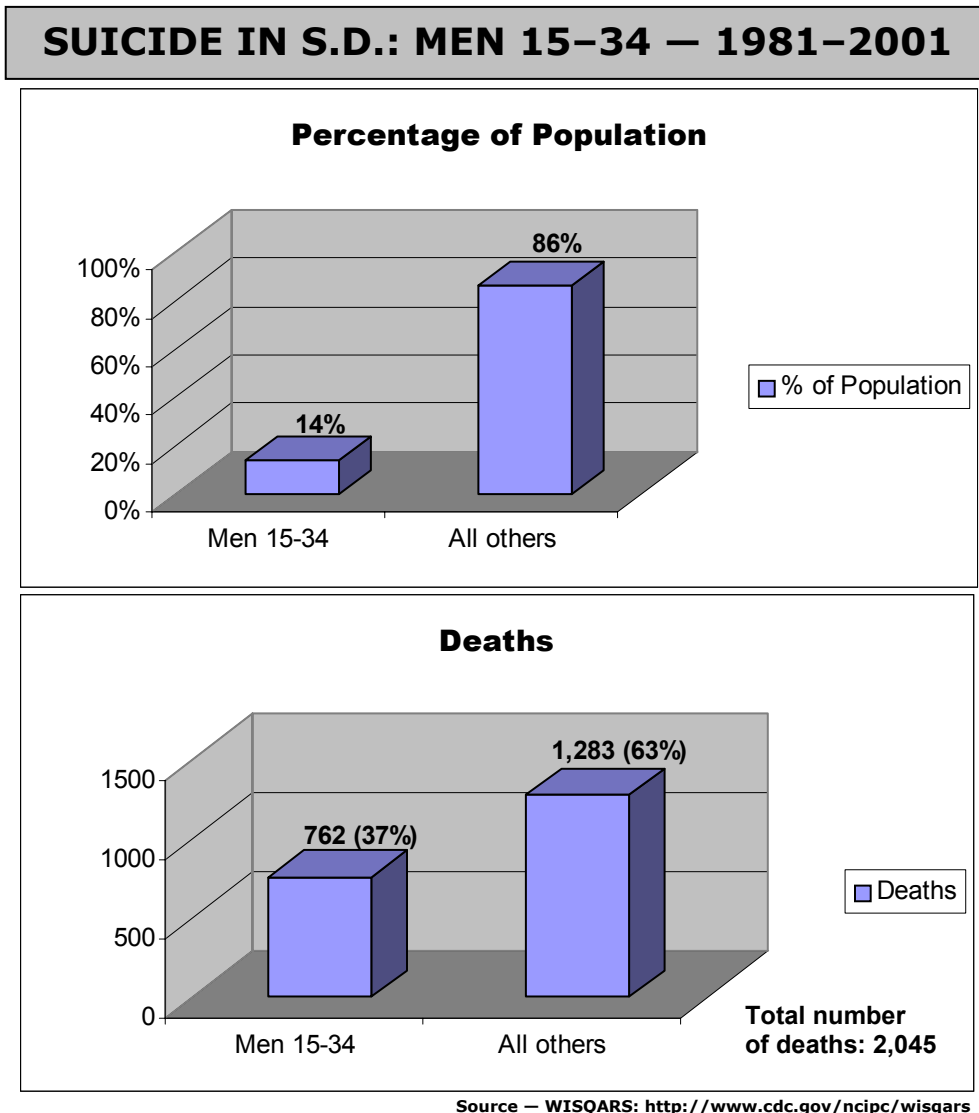
People of almost every age die by suicide.¹⁴ One young person dies by suicide every month. The largest number of suicides—four out of 10—are among people entering adulthood and those living in what is often called the “prime of life.” And suicide strikes across the lifespan, with two out of 10 deaths among the elderly. Almost 90 suicide deaths each year are whites. Native Americans—who make up 8 percent of South Dakota’s population—account for 15 percent of the suicides (16 deaths per year).

A DECADE OF S.D. SUICIDES (1,068 Deaths) — 1993–2002								
BY AGE	Youth (10–19)		Young Adults (20–39)		Older Adults (40–59)		Elderly (60-plus)	
	Total	Annu al	Total	Annu al	Total	Annu al	Total	Annu al
Deaths	128	13	423	42	289	29	218	22
Percentage	12%		40%		27%		21%	
BY RACE	Whites		Native Am.		Other			
	Total	Annu al	Total	Annu al	Total	Annu al		
Deaths	897	90	162	16	9	1		
Percentage	84%		15%		1%			
BY SEX	Men		Women					
	Total	Annu al	Total	Annu al				
Deaths	915	92	153	15				
Percentage	86%		14%					
Source — S.D. Department of Health								

13. All data is from the S.D. Department of Health unless otherwise noted.

14. Suicide is rare in very young children (about five children under 10 years old die of suicide each year in the United States). Source — WISQARS: <http://www.cdc.gov/ncipc/wisqars>

The overwhelming majority of suicide victims are men, even more so in South Dakota (86 percent) than in the United States as a whole (80 percent).¹⁵ In fact, youth and young adult males (ages 15–34) make up 14 percent of the state’s population, but they account for 37 percent of the suicides (762 of the 2,045 suicides in 1981–2001 in South Dakota were 15– to 34-year-old men).



15. Kochanek, *Deaths: Final data for 2002*.

While the suicide rate for all young men in South Dakota is alarmingly high, among young Native American men in the state, suicide is truly epidemic.

For Native American men 15–39, the suicide rate in South Dakota is four times the death rate of their white counterparts in the state. And the suicide rate for 15- to 39-year-old Native American men in the state is three- to three-and-a-half times the average rate for their Native American peers throughout the United States. In fact, 2 percent of the U.S. Native American population lives in South Dakota, but Native American suicide deaths in the state make up 5 percent of all Native American suicides in the nation.

In addition, suicide in the Native American community sometimes occurs in clusters. It is called a *suicide cluster*¹⁶ when knowledge of a suicide death or deaths influences other people who are at risk to act out increased suicidal behavior (also known as *suicide contagion*). A recent cluster occurred on the Cheyenne River Indian Reservation in Dewey County beginning in the fall of 2001, when nine people died of suicide in less than 11 months. Eight of the nine fatalities were men and six of the nine were teenagers.¹⁷ Periods of heightened suicidal behavior in small populations in South Dakota are not unique to Native American communities. Between 1995 and 1997, there were 12 suicides in Hughes County, eight of them teenagers.¹⁸ That epidemic of suicide among young people gained national attention when it was featured in an episode of *In the Mix*, a Public Broadcasting Service program for teens.¹⁹

16. A dictionary of suicide prevention terms begins on page 45.

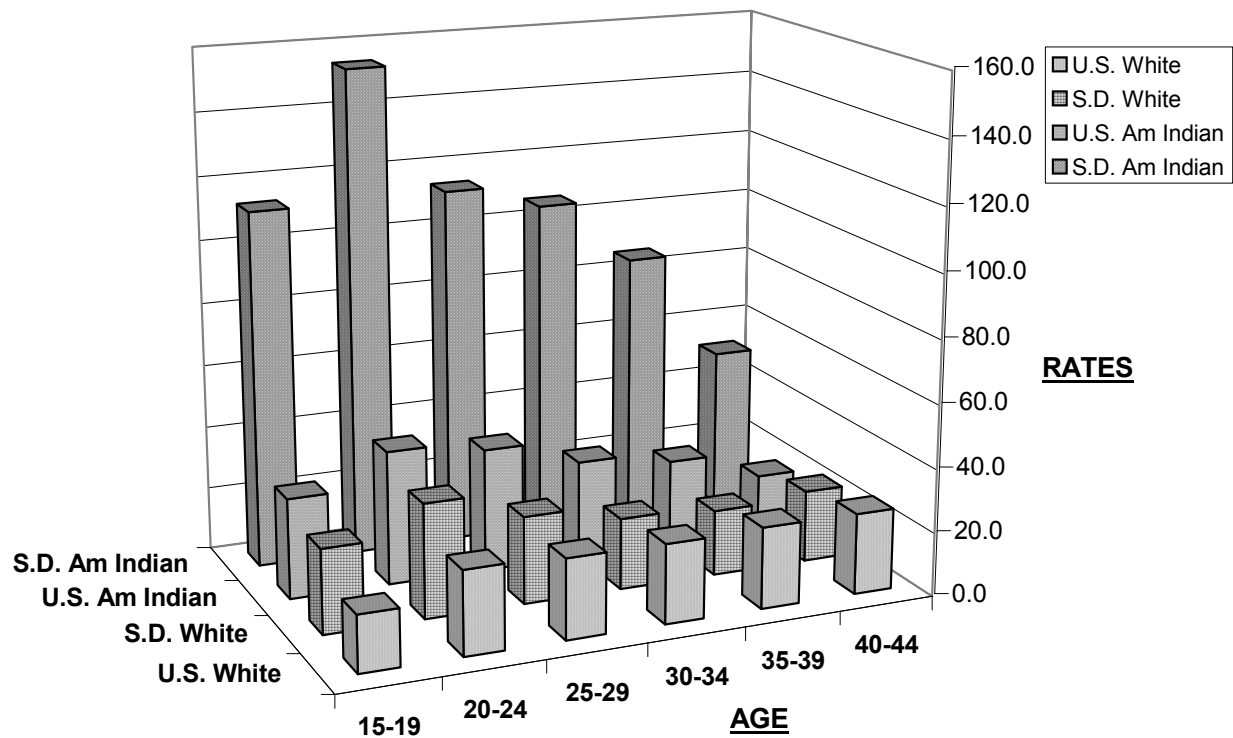
17. Data compiled by Aberdeen Area Office of Indian Health Services.

18. Unofficial figures provided by Ellen Lee, Executive Director, St. Mary's Foundation, Pierre.

19. *In the Mix: Depression: On the Edge*. New York City: Castle Works and WNYC Radio, 1998.

U.S. AND S.D. MEN — 1989–1998

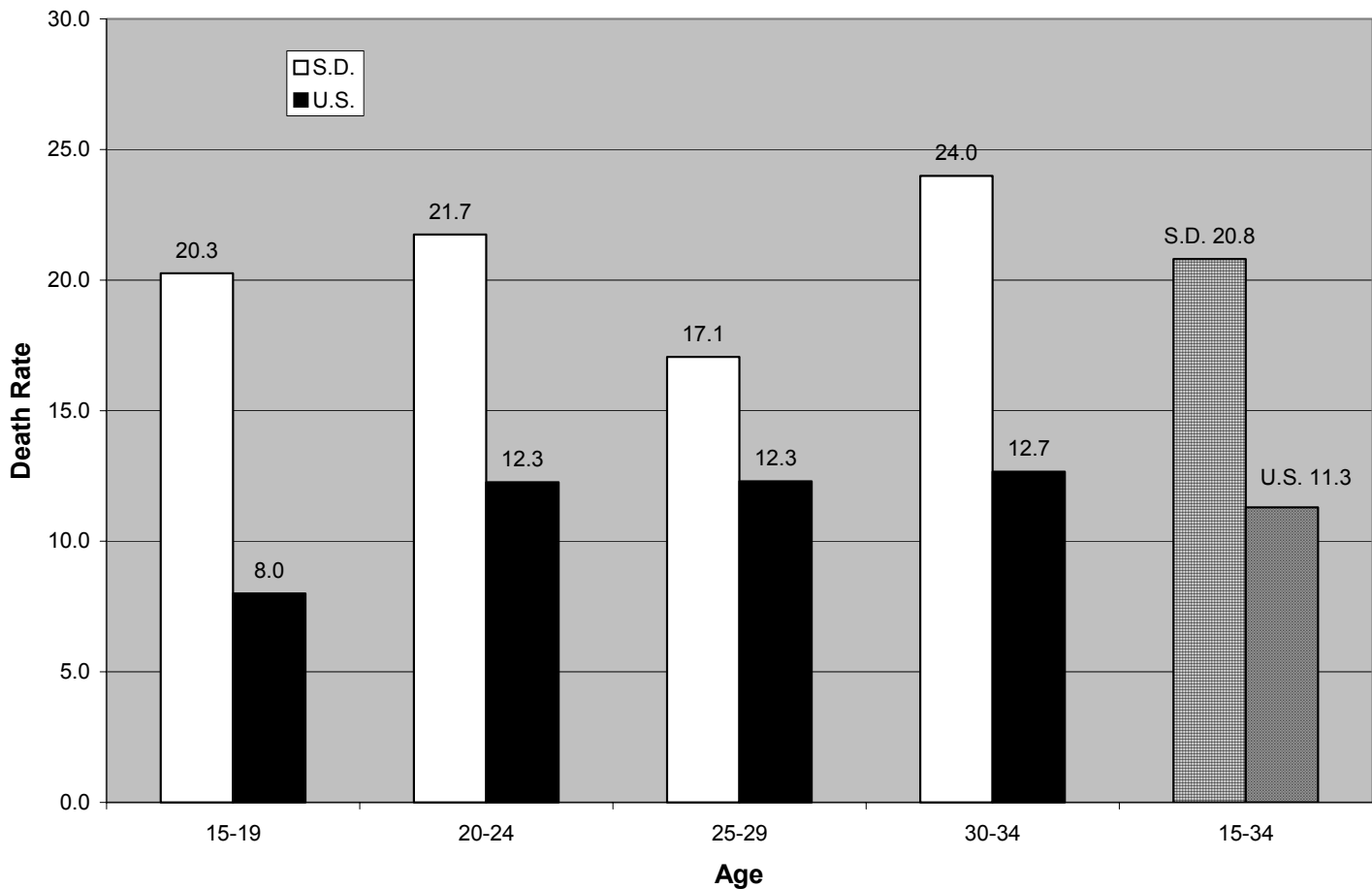
SUICIDE RATES OF WHITES AND NATIVE AMERICANS



	15-19	20-24	25-29	30-34	35-39	40-44
U.S. White	17.7	26.2	25.0	24.9	25.5	25.4
S.D. White	26.5	35.8	27.4	22.4	20.6	22.7
U.S. Am Indian	31.6	42.2	38.9	30.8	27.0	18.1
S.D. Am Indian	112.5	153.7	113.4	106.0	85.6	50.8

Suicide is the second-leading cause of death in South Dakota for people 15–34, regardless of sex or race. The suicide rates for youth and young adults in the state (20.8) is about twice as high as it is in the nation overall (11.3), and the S.D. suicide rate for 15- to 19-year-olds (20.3), is two-and-a-half times as high as it is nationally (8.0).

S.D. AND U.S. SUICIDE: YOUTH AND YOUNG ADULTS — 1999–2001



Elderly white men are also at a distinctly high risk for suicide, both in South Dakota and throughout the country. Suicide rates during the 10-year period 1989–1998 for white men ages 65–69 were 24.0 per 100,000 in South Dakota and 26.1 in the United States; 34.0 and 32.8 for ages 70–74; 48.2 and 43.0 for ages 75–79; 59.3 and 55.2 for ages 80–84; and 48.6 and 64.0 for white men older than 85.²⁰

The problem of high overall suicide rates as well as the presence of populations with exceptionally high suicide rates prompted the South Dakota Legislature in 2003 to pass Senate Concurrent Resolution No. 5 (see Appendix A, page 42). The legislation asks that “the prevention of suicide be made a state priority” and supports “the creation of a South Dakota plan for suicide prevention that will lay the groundwork for suicide prevention efforts that are designed specifically for use in South Dakota communities and based on the principles outlined in the National Strategy for Suicide Prevention.”

S.D. & U.S. SUICIDE RATES, RANKINGS, FATALITIES					
Year	U.S. Rate	S.D. Rate	S.D. vs. all states	S.D. Deaths	U.S. Deaths
1990	12.4	13.1	21st	91	30,906
1991	12.2	13.5	15th	95	30,810
1992	12.0	11.2	39th	79	30,484
1993	12.1	16.3	8th	117	31,102
1994	12.0	13.5	17th	97	31,142
1995	11.9	11.8	33rd	86	31,284
1996	11.6	16.9	7th	124	30,903
1997	11.4	17.2	7th	127	30,535
1998	11.3	15.6	11th	115	30,575
1999	10.7	14.0	12th	103	29,199
2000	10.7	12.9	18th	95	29,350
2001	10.8	13.8	15th	105	30,622
2002	11.0	12.4	22nd	94	31,655
Sources — “U.S.A. Suicide: State and Regional Data, 1990-1999 and 2000” at http://mypage.iusb.edu/~jmcintos/SuicideStates.html; Deaths: Final data for 2001. National Vital Statistics Reports; Deaths: Final data for 2002. National Vital Statistics Reports					

20. WISQARS: <http://www.cdc.gov/ncipc/wisqars>

NONFATAL SUICIDAL BEHAVIOR

Suicide's toll also includes the injuries resulting from suicide attempts that do not result in fatalities. Accurate national data are not available on nonfatal suicide attempts, and recent estimates range from about 6 attempts²¹ to 22 attempts²² requiring treatment in emergency rooms for every death by suicide in the United States. Applying those ratios of deaths to attempts in South Dakota suggests that there are between 640 and 2,350 suicide attempts annually in the state that require emergency medical treatment.

One of the state's most populous counties (Pennington County) kept track from December 2003 through September 2004 of suicide attempts among people for whom petitions were filed to have them placed on involuntary mental holds;²³ during those 10 months, there were 85 suicide attempts. Given the average of one suicide per month in Pennington County, there would be roughly 8.5 attempts in that population for every completed suicide. But there is no doubt that there are many more attempts than only those that occur among people the authorities identify through the involuntary mental hold process.

At issue is the fact that consistent and complete data are not systematically collected or reported on suicide attempts in South Dakota. During the development of the SDSSP, the hospitals in South Dakota contacted by the SDSSP Workgroup indicated that they do not routinely track such data either for internal use or as part of a centralized, statewide system. The uncertainty and guesswork encountered by the Workgroup in assessing the prevalence and nature of nonfatal suicide attempts in the state highlights the need for a reporting system to provide information that would help healthcare planners design programs to prevent suicidal behavior.

The National Strategy for Suicide Prevention calls for improved data collection on suicidal behavior because it is "key to health planning." The data "are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts." Because "detailed information ... may lead to increased knowledge of how suicides can be prevented in the future,"²⁴ the South Dakota State Strategy for Suicide Prevention calls for increasing "the proportion of health professionals who collect uniform and reliable data on suicidal behavior" (Objective 7.2, page 41).

21. Ikeda, R.M., et al. "Nonfatal Self-Inflicted Injuries Treated in Hospital Emergency Departments—United States, 2000." *Morbidity and Mortality Weekly Report* 2002, 51 (20), 436–438.

22. *Reducing Suicide*, 17.

23. An involuntary mental hold is a legal procedure used to mandate care for a person that will protect him from harming himself or others.

24. *NSSP*, 117, 119.

Finally, the severity of injuries resulting from suicide attempts highlights the cost of suicidal behavior to individuals and communities. One study reports that 48 percent of those treated for self-inflicted injuries in emergency rooms had serious enough injuries that they required hospitalization or were transferred to another facility for treatment. In addition, self-inflicted injuries disproportionately affect the young, with the highest incidence among people age 15–24 and especially among females 15–19.²⁵

A PUBLIC HEALTH RESPONSE TO SUICIDE

Anyone seriously interested or involved in a public health approach to preventing suicide should be familiar with *the National Strategy for Suicide Prevention*.²⁶ It was developed by people with the most knowledge and experience in the country on the topic, who worked together in a broad-based, public-private partnership that represented everyone who has a stake in suicide prevention. When the NSSP was released by then-U.S. Surgeon General Dr. David Satcher in May 2001, it represented the best science available on suicidal behavior and suicide prevention in the United States. The NSSP; *Mental Health: A Report of the Surgeon General*;²⁷ *Reducing Suicide: A National Imperative*;²⁸ and the report of the President's New Freedom Commission on Mental Health²⁹ are today the seminal documents guiding the suicide prevention movement in the United States.

Careful consideration of the concepts and recommendations in those documents is essential to effective suicide prevention, but it is beyond the scope of the South Dakota Strategy for Suicide Prevention to give an in-depth summary of those concepts and recommendations. However, the excerpted material below from the NSSP is essential, for it describes how a public health approach can be used to respond to suicide at the state and community levels.

25. Ikeda, "Nonfatal Self-Inflicted Injuries."

26. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. (NSSP) Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, 2001. Available at <http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp>.

27. *Mental Health: A Report of the Surgeon General*. Rockville, Md.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Available at <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

28. *Reducing Suicide: A National Imperative*. Washington, D.C.: Institute of Medicine, 2002. Available at <http://www.nap.edu/books/0309083214/html>.

29. *New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Rockville, Md.: U.S. Department of Health and Human Services, 2003. Available at <http://www.mentalhealthcommission.gov/reports/reports.htm>.

A public health approach has five components:

- Clearly define the problem
- Identify risk and protective factors
- Develop and test interventions
- Implement interventions
- Evaluate effectiveness

Clearly define the problem. Collecting information about the rates of suicide and suicidal behavior is known as surveillance. Surveillance may also include collection of information on the characteristics of individuals who die by suicide, the circumstances surrounding those incidents, possible precipitating events, and the adequacy of social support and health services. Surveillance helps to define the problem for a community.

While national data provide an overall view of the problem, state and local suicide rates vary considerably from national rates. Local data are key to effective prevention efforts. It is important to note, however, that local suicide rates, due to the significant fluctuations that occur in small populations, are often not useful in evaluating the effectiveness of suicide prevention programs in the short-run.

Identify risk and protective factors. Risk factors may be thought of as leading to or being associated with suicide; that is, people “possessing” a risk factor are at greater potential for suicidal behavior. Protective factors, on the other hand, reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental, or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.

RISK FACTORS FOR SUICIDE

➤ Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

- Environmental Risk Factors
 - Job or financial loss
 - Relationship or social loss
 - Easy access to lethal means
 - Local clusters of suicide that have a contagious influence
- Sociocultural Risk Factors
 - Lack of social support and sense of isolation
 - Stigma associated with help-seeking behavior
 - Barriers to accessing health care, especially mental health and substance abuse treatment
 - Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
 - Exposure to and influence of others who have died by suicide, including exposure through the media

PROTECTIVE FACTORS FOR SUICIDE

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Develop and test interventions. Suicide prevention interventions reduce risk or enhance protective factors; some address both. Interventions, like risk and protective factors, may be characterized through biopsychosocial, environmental, and sociocultural dimensions. An intervention might attempt to influence some combination of psychological state, physical environment, or cultural conditions. Alternatively, suicide prevention efforts have been classified as either universal, selective, or indicated: a universal approach is designed for everyone in a defined population regardless of their risk for suicide, such as a health care system, or a county, or a school district; a selective approach is for subgroups at increased risk, for example, due to age, gender, ethnicity or family history of suicide; and an indicated approach is designed for individuals who, on examination, have a risk factor or

condition that puts them at very high risk, for example, a recent suicide attempt.³⁰

Rigorous scientific testing of interventions prior to large-scale implementation is important to ensure that interventions are safe, ethical, and feasible ... In actuality, definitive pilot studies are frequently missing for many types of social and mental health interventions, including those designed to prevent suicide. By default, program planners may incorporate “promising” interventions into community suicide prevention plans before the evidence base is fully developed. This makes careful evaluation of local outcomes especially important.

Implement interventions. State and local organizations will often develop suicide prevention programs that consist of a broad mix of interventions. By selecting interventions that include universal, selective, and indicated approaches, a more comprehensive program can be developed.

Considerations for selecting the elements of a program, i.e., the mix of interventions that will be implemented, include local needs (based on a specific assessment of the problem of suicide in the community) and an analysis of cost vs. potential effectiveness of different interventions. Moreover, program planners will need to consider ways to integrate interventions into existing programs and to strengthen collaboration. Such comprehensive suicide prevention programs are believed to have a greater likelihood of reducing the suicide rate than are interventions that address only one risk or protective factor, particularly if the program incorporates a range of services and providers within a community. Comprehensive programs engage community leaders through coalitions that cut across traditionally separate sectors, such as health and mental health care, public health, justice and law enforcement, education and social services. The coalitions involve a range of groups, including faith communities, civic groups, and businesses. Suicide prevention programs need to support and reflect the experience of survivors, build on community values and standards, and integrate local cultural and ethnic perspectives.³¹

Evaluate effectiveness. It is important to note that most interventions that are assumed to prevent suicide, including some that have been widely implemented, have yet to be evaluated. An ideal *evidence-based* intervention is one that has been evaluated and found to be safe, ethical, and feasible, as well as effective. Determination of cost effectiveness is

30. Gordon, R.S. “An Operational Classification of Disease Prevention.” *Public Health Reports*, 98 (1983), 107–109.

31. *Mental Health: A Report of the Surgeon General*.

another important aspect of evaluation. Evaluation can help determine for whom a particular suicide prevention strategy is best fitted or how it should be modified in order to be maximally effective.³²

MENTAL HEALTH CARE AND ADDICTION RECOVERY SERVICES

Two of the main contributing factors to suicide are inadequately treated mental illness and the abuse of drugs, including alcohol.

The National Institute of Mental Health reports “research has shown that more than 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.”³³ Likewise, the Institute of Medicine’s *Reducing Suicide: A National Imperative* states that “suicides in ... the United States are most commonly associated with a diagnosis of a mood disorder in adults and adolescents”³⁴ (mood disorders include major depressive disorder and bipolar disorder, also known as manic-depressive illness).

Among those who chronically abuse alcohol, it is estimated that as many as 15 percent may eventually kill themselves, and those who abuse drugs have a risk of suicide as much as 20 times higher than that of the general population.³⁵ Alcohol and other drugs also can play a role when impulsiveness is a factor in the decision to act, and are particularly implicated in suicides among young men.³⁶

Untreated mental illness and drug and alcohol abuse are recalcitrant problems that have for ages severely damaged the well-being of individuals and families and undermined the strength of communities. Because of their direct impact, for better or for worse, on suicidal behavior, any public health response to suicide must give special attention to the efficiency and effectiveness of the systems in place to handle basic mental health care and addiction recovery services.

S.D. mental health care services. The mental-health-care system in rural America, according to the President’s New Freedom Commission on Mental Health, is hampered by “critical barriers to care ... [that] result in an ‘experience of care’ for rural Americans that too often includes a delay in care, inconsistent care, or no care.”³⁷

32. *NSSP*, 29–40.

33. “In Harm’s Way: Suicide in America.” Rockville, Md.: U.S. Department of Health and Human Services, National Institute of Mental Health, January 2001 (rev. May 2003).

34. *Reducing Suicide*, 71.

35. Faulkner, Alison. “Suicide and Deliberate Self-Harm: The Fundamental Facts.” London: The Mental Health Foundation, May 1997.

36. *Ibid.*

37. “New Freedom Commission on Mental Health, Subcommittee on Rural Issues: Background Paper.” Rockville, Md.: U.S. Department of Health and Human Services, 2004, 1.

The commission's Subcommittee on Rural Issues states that "the facts are clear:"

- "Although rural Americans' prevalence and incidence of mental disorders is comparable to their urban counterparts, they are much less likely to have access to services or providers.
- "Rural teens and rural older adults have a much higher rate of suicide than do their urban peers.
- "Rural residents are less likely to have health insurance with a mental health benefit, and financial resources available to support mental health systems are less robust.
- "Programs to specifically train and promote the placement of rural mental health professionals are not available, and those that do exist are often not located in rural areas."³⁸

It is clear that South Dakota is not an exception to the rule regarding mental-health care in rural America. Survey results in the South Dakota Children's Mental Health Task Force final report outline critical shortages in the state in family support, school-based mental health services, intensive in-home family therapy, wraparound services (systems for long-term mental-health care in a youth's own family and community), and early identification and screening. The survey results show that the least available providers in South Dakota are psychiatrists, psychologists, and family therapists.³⁹

The task force recommendations include increasing the availability of mental health professionals and addressing "significant gaps" in the continuum of mental health services. In addition, the task force points out that "the first step in seeking care is the knowledge regarding both the need for help and where to go for help" and recommends a statewide public education campaign to increase South Dakotans' "awareness of ... mental health issues and local resources for care."⁴⁰ That recommendation ties in directly with the SDSSP's call for initiatives to increase public knowledge of suicide prevention (see Goal 2, page 37).

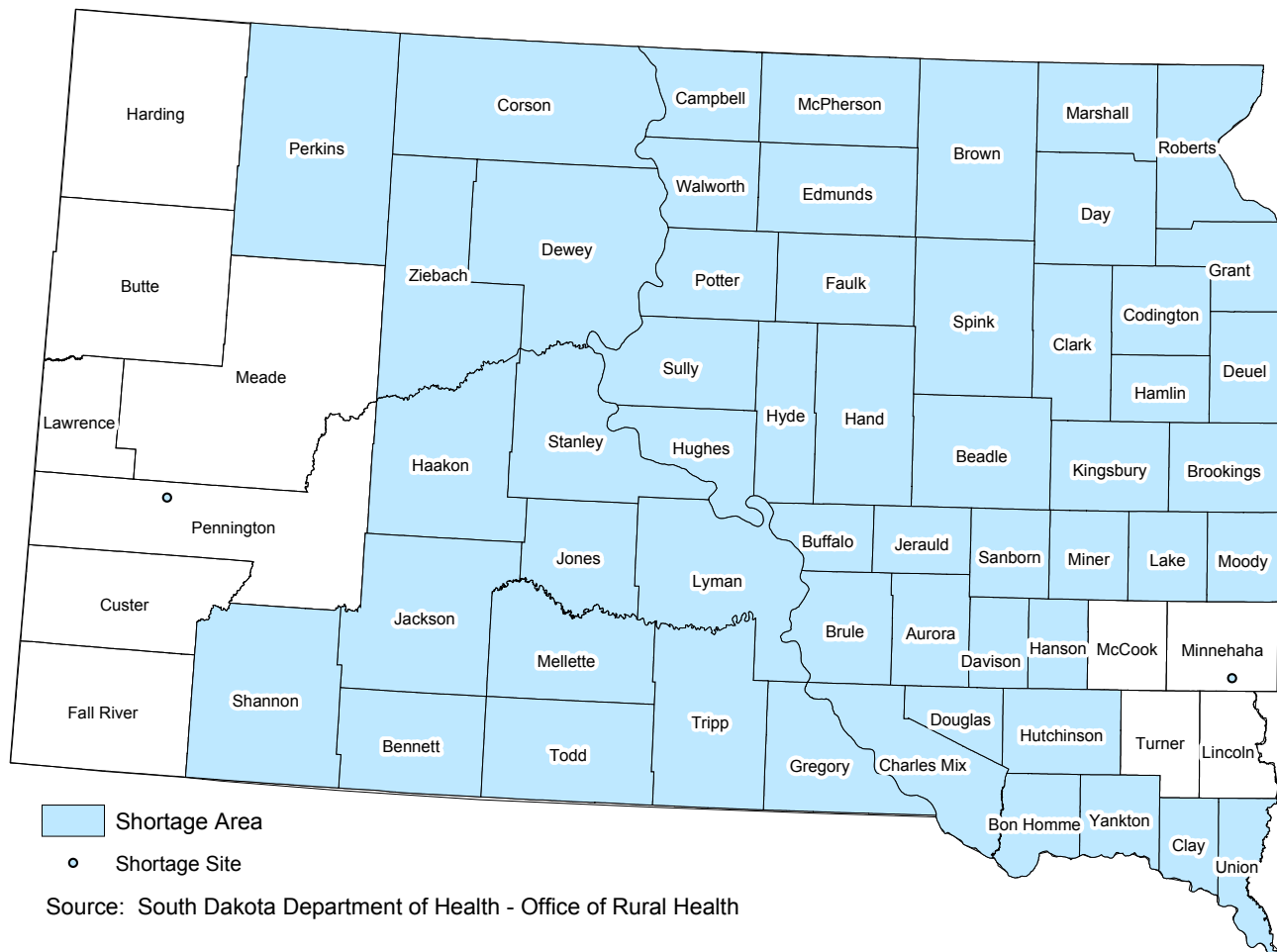
Even though the task force focused on children's mental health services, its conclusions can be generalized to mental health care services for people of all ages in South Dakota. All but 11 of South Dakota's 66 counties are officially designated by the U.S. Department of Health and Human Services as Mental Health Professional Shortage Areas.

38. Ibid.

39. WICHE Mental Health Program. "South Dakota Children's Mental Health Task Force: Final Report." Pierre: S.D. Department of Human Services, Division of Mental Health, 2003, 38.

40. Ibid., 50

SOUTH DAKOTA HEALTH PROFESSIONAL SHORTAGE AREAS MENTAL HEALTHCARE June 15, 2004



And several other counties miss the mark only because of a flaw in the methodology used to designate MHPSA's in South Dakota.⁴¹ The MHPSA designation is given to counties that lack adequate core mental health professionals, defined as psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

Here is a 1998 summary of the status of South Dakota's mental health care personnel:

- 5.5 psychiatrists per 100,000 population (ranked 45th), compared to the national average of 11.1
- 17.8 psychologists per 100,000 population (ranked 45th), compared to the national average of 31.2
- 279 social workers per 100,000 population (ranked 12th), compared to the national average of 216⁴²

Finally, one of the most insidious barriers to people getting mental health care services is the stigma associated with seeking help for mental, emotional, or behavioral problems—and stigma is often more pronounced in rural areas. That stigma “leads to under-diagnosis and under-treatment of mental disorders among rural residents.”⁴³ Embarrassment about seeing a mental health care professional, combined with the lower number of caregivers, also results in primary health care providers being “the dominant providers of mental health care in rural areas.”⁴⁴ That in turn increases the need for more specialized training among general health care practitioners as well as the need for improved collaboration and referral mechanisms among primary care, addiction recovery, and mental health care systems—aims that will be difficult to achieve in rural South Dakota.

S.D. addiction recovery services. A recent study by the National Center on Alcohol and Drug Abuse found that “the rate of drug, alcohol and nicotine use among young teens in rural America is now higher than in the nation's large urban centers, and the rates of adult drug, alcohol, and nicotine use are about the same in rural towns and mid-size cities as in large urban centers.”⁴⁵

41. Nov. 24, 2004 e-mail correspondence from Terry Dosch, Executive Director, S.D. Council of Community Mental Health Centers: South Dakota's analysis is not done county-by-county but rather is done according to the areas served by the Community Mental Health Centers (called “catchment areas”), overstating the availability of mental health professionals in counties near Rapid City and Sioux Falls.

42. “HRSA State Health Workforce Profiles: South Dakota.” Rockville, Md.: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Information & Analysis, Bureau of Health Professions, December 2000, 68.

43. “Mental Health in Rural America.” National Rural Health Association, May 1999. Available at <http://www.nrharural.org/dc/issuepapers/ipaper14.html>.

44. Ibid.

45. “No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America.” New York: National Center on Addiction and Substance Abuse, January 2000.

According to the 2002 “National Survey on Drug Use and Health,” South Dakota

- ranks in the top 20 percent of states for the prevalence of alcohol dependence or abuse;
- ranks in the top 20 percent of states in the number of people who need but do not receive treatment for alcohol problems;
- is among seven states where 12- to 17-year-olds were in the top 20 percent in the use of both marijuana and other illicit drugs; and
- is among three states that were in the top 20 percent for all age groups (12–17, 18–25, 26–older) when it comes to the prevalence of binge drinking.⁴⁶

For young people in South Dakota, the use of drugs and alcohol is commonplace. According to the 2003 South Dakota Youth Risk Behavior Survey, among the state’s high school-age youth:

- 76 percent drank alcohol sometime during their lifetime
- 25 percent drank alcohol before they were 13 years old
- 50 percent had a drink within the past 30 days
- 38 percent had 5 or more drinks in a row in the past 30 days
- 37 percent used marijuana sometime during their lifetime
- 21 percent used marijuana in the past 30 days
- 7 percent used cocaine or methamphetamines during their lifetime⁴⁷

During the last three years, the use of methamphetamines by youth and young adults has greatly exacerbated the problem of substance abuse in the state, a situation shared by the majority of Frontier and Rural states in the Midwest.⁴⁸ In the past four years, the proportion of individuals in South Dakota presenting themselves for addiction recovery treatment primarily for methamphetamine abuse has gone from 7 percent to 10 percent to 19 percent to 24 percent.⁴⁹ The sudden influx of large numbers of methamphetamine addicts—who require more intensive treatment for a longer period of time with more substantial follow-up—has increased the burden on the state’s already overtaxed addiction treatment capacity.

At the same time the prevalence of drug and alcohol use in South Dakota is a significant concern, the same problems that hamper the delivery of mental health services in sparsely populated areas (strained financial resources, long-distance transportation needs, lack of training infrastructure

46. Wright, Douglas. *State Estimates of Substance Use from the 2002 National Survey on Drug Use and Health*. Rockville, Md.: U.S. Department of Health and Human Services, 2004, 71-72.

47. Schubot, David B. “South Dakota Youth Risk Behavior Survey Report 2003.” Pierre: S.D. Department of Education, S.D. Department of Human Services.

48. *Epidemiologic Trends in Drug Abuse*. Rockville, Md.: U.S. Department of Health and Human Services, National Institutes of Health, December 2003.

49. Data from the S.D. Division of Alcohol and Drug Abuse.

for professionals, no economies of scale to support specialized services, and the stigma attached to help-seeking) also negatively affect the availability of effective addiction recovery services.

Among the findings of a 2002 report to the South Dakota Division of Alcohol and Drug Abuse are the following:

- “The majority of accredited facilities that provide [addiction recovery] services to adults fall along the major interstate highways in the state, I-29 and I-90.”
- The most intensive services are the least available ones; for example, “day treatment services for adults were available in only three counties statewide.”
- The type of intensive treatment services required by Native American communities “tend to be distant from reservations.”
- More than 80 percent of treatment slots in the state, outside of correctional facilities, were for outpatient services.
- Eighty percent of the adult treatment slots were in the eastern part of the state, and the “need and demand for services” justifies “additional capacity to meet demand at higher levels of care,” especially in the western part of the state.⁵⁰

Mental health care parity in S.D. A major roadblock to adequate, accessible mental health care and addiction recovery services involves *mental health care parity* (the requirement that insurance companies cover mental illness “on par” with the coverage of other illnesses in terms of caps on treatments or services, maximum allowable pay outs, and so forth). South Dakota is among the states with a law that does include a provision for mental health care parity, but it applies only to severe mental illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and a number of anxiety disorders.⁵¹ In addition, the law does not apply to self-insured health plans (which cover about 75,000 people in South Dakota)⁵² because they are exempt from state insurance requirements under the federal Employee Retirement Income Security Act (ERISA). In addition, pre-existing conditions are not protected by the mental health parity law, and insurance carriers usually opt to deny coverage outright in those cases.⁵³

50. “Assessment of the Current Substance Abuse Treatment System in South Dakota.” Pierre: S.D. Department of Human Services, S.D. Division of Alcohol and Drug Abuse, March 2002, ES1-2.

51. S.D. Codified Law 58-17-98 (Health Insurance Policies). Also cited in SDCL 58-18-80 (Group & Blanket Health Insurance Policies), SDCL 58-18B-53 (Small Businesses’ Group & Blanket Health Insurance), SDCL 58-38-40 (Non-Profit Medical and Surgical Plans), SDCL 58-40-37 (Non-Profit Hospital Service Plans), and SDCL 58-41-115 (Health Maintenance Organizations).

52. Oct. 4, 2004 e-mail correspondence from Randy Moses, Assistant Director–Regulation, Division of Insurance, S.D. Department of Revenue & Regulation.

53. Sep. 30, 2004 e-mail correspondence from Terry Dosch, Executive Director, S.D. Council of Community Mental Health Centers.

The exclusions (no coverage except for severe mental illness and no coverage for self-insured plans) plus the fact that at least 8.1 percent of South Dakotans (more than 60,000 people) have no health insurance at all⁵⁴ combine to create a serious impediment to people receiving care for two of the most significant causes of suicide.

SURVIVORS OF A LOVED ONE'S SUICIDE

The term "suicide survivor" refers to family members and others who have been affected by the death of a loved one by suicide. They are those left behind—parents, grandparents, husbands, wives, children, siblings, cousins, lovers, friends, colleagues, classmates—who must grieve "an almost unfathomable kind of loss."⁵⁵

There are no official statistics or epidemiological studies to accurately determine the number of suicide survivors. It has been estimated that there are approximately six survivors on average for each suicide.⁵⁶ Using that ratio, the 31,655 suicides in 2002 in the United States would have left behind 189,930 survivors. From 1978 through 2002, there were 745,000 suicides in the United States, so based on the 6:1 ratio, there would be almost 4.5 million survivors nationwide, 1 in every 64 Americans in 2002.

South Dakota's average of 107 suicides per year indicates that there are as many as 640 new survivors in the state annually. It follows, then, that in any single generation (30 years) of South Dakotans, there would be approximately 19,000 survivors of suicide.

The grief a survivor experiences can be devastating and even debilitating.⁵⁷ The nature of suicide itself sets it apart as a traumatic event that is incomprehensible to those who have not experienced it themselves. Because suicide is usually sudden and unexpected, survivors often react with shock, numbness, and disbelief. Many suicides are violent, which can increase survivors' sense of shock and also cause post-traumatic stress symptoms such as intrusive, disturbing images, incessant anxiety, or the need to be "on guard."

54. "Health Insurance Coverage in South Dakota: Final Report of the State Planning Grant Program." Pierre: S.D. Department of Health, March 29, 2002, 1.

55. Jamison, Kay Redfield. *Night Falls Fast: Understanding Suicide*. New York: Alfred A. Knopf, 1999.

56. Shneidman, Edward S. "Prologue: Fifty-eight years" in *On the Nature of Suicide*, Ed. E.S. Shneidman. San Francisco: Jossey-Bass, 1969.

57. The descriptions of the characteristics of survivor grief are based on "Survivors of Suicide Curriculum" by John McIntosh and Richard Hubbard, University of Indiana South Bend, available at <http://mypage.iusb.edu/~jmcintos/Survivors.Main.html>.

Societal stigma about people who die by suicide sometimes combines with survivors' feelings of shame and guilt, preventing them from getting the full benefit from society's normal mourning rituals, such as viewings, wakes, funerals, and burial ceremonies. Survivors also can be obsessed with questions that torment them, such as "Why did this happen?" and "If I had (or hadn't) done (or not done) this (or that), would my loved one still be alive?" In addition, suicide can tear at the fabric of a family, with people blaming each other for the death.

Perhaps one of the most confusing and disconcerting feelings survivors have is anger. Survivors sometimes feel intense and long-lasting anger toward their loved one, toward people they think are at fault in the death, toward themselves, or toward God.

A death by suicide can isolate people who are emotionally close to the deceased. It is not uncommon for survivors to feel strongly that no one can understand what is happening to them and to shy away from contact with other people. Again, stigma plays a role in isolating survivors of suicide, and it is exacerbated by the fact that, quite often, neither the survivor nor anyone else knows what to say or do when faced with talking about a death by suicide.

Finally, survivors may themselves experience depression or have suicidal thoughts. There is evidence that family members of someone who died by suicide have a higher risk of suicide than the general population.

There is help for survivors, ranging from individual therapy to self-help support groups.

Therapy can be arranged with any licensed counselor, but survivors often benefit from working with a counselor (or minister or other spiritual adviser) who specializes in grief therapy. Also, survivors who have been directly traumatized by their experience (for example, people who discover the body of their loved one) should be assessed for post-traumatic stress symptoms.

Support groups include general grief support groups, such as Compassionate Friends (for people who have experienced the death of a child regardless of the cause of death) and so-called peer-led support groups that are run by suicide survivors themselves for the benefit of other survivors. Some specialized suicide survivor support groups are also facilitated by a clinician who may or may not be a survivor. In South Dakota, there are suicide survivor support groups in Huron, Madison, Sioux Falls, and Rapid City.

Many people find support groups particularly helpful. The aftermath of a death by suicide can overwhelm a person's ability to cope—physically, mentally, emotionally, and spiritually. But finding the fellowship of people

who have “been there” can be a first step toward finding a way to deal with what has happened.

Assisting survivors as quickly as possible after the death of a loved one can increase the chance that they will reach out for help with their grief. Research on the Baton Rouge Crisis Intervention Center’s outreach teams (LOSS teams, which stands for Local Outreach to Survivors of Suicide) has demonstrated that visiting suicide survivors immediately after the death reduces the length of time for them to seek assistance from years to an average of 39 days.⁵⁸

There are two survivor outreach programs in South Dakota that provide immediate assistance to survivors, one in Rapid City and the other in Sioux Falls. They dispatch a volunteer team made up of an experienced and trained survivor along with a mental health professional to be with the survivors as soon as possible after the death. The teams provide support, information, referral, and hope for new survivors.

COMMUNITY SUICIDE PREVENTION TOOLKIT⁵⁹

In his Preface to the *National Strategy for Suicide Prevention*, U. S. Surgeon General Dr. David Satcher notes that “Much of the work of suicide prevention must occur at the community level, where human relationships breathe life into public policy.”⁶⁰ It is in keeping with that spirit that the implementation of the SDSSP is designed to be guided by South Dakota communities themselves. The Toolkit will be available to leaders and stakeholders throughout South Dakota who want to reduce suicide attempts and completions in their communities.

In order to help South Dakota community members understand suicide, suicide prevention, and suicide aftercare, the Toolkit will include

- practical tools and reference materials,
- examples from existing programs,
- resources for training and technical assistance,
- guidance for planning and implementation, and
- instruction on organizing a community.

There are several community-based task forces working on suicide prevention in the state; in almost every case, they were initiated in the wake of an increase in suicides in those communities. The Toolkit will help improve the work in communities where formal efforts are already in place, and it will

58. Campbell, F. R. “An Active Postvention Model.” *Crisis*, 24 (4), 2003.

59 For an example, see Texas’s community toolkit at http://www.mhatexas.org/SuicidePreventToolkit8_04.htm.

60. *NSSP*, 2.

give all South Dakota communities a way to be proactive in their suicide prevention efforts. The contents of the Toolkit will be based on the most current research available and will include programs already being used throughout the country. Using those resources, the response to suicide in South Dakota can become the most effective, systematic, and consistent one possible.

The Toolkit is presently under development, and its specific components are being selected and assembled during the next phase of the development of the SDSSP. In general, its components will cover:

- Empowering community stakeholders to address the issue of suicide prevention
- Gathering local information about suicide and suicidal behavior
- Engaging leaders and community systems and resources in the solution
- Developing and implementing programs for
 - prevention (to help people before a crisis develops)
 - intervention (to help people who are presently at high risk)
 - aftercare (to help people who have lost a loved one to suicide)

Objective 1.1 of the SDSSP calls for “a centralized clearinghouse to coordinate and enhance suicide prevention efforts.” The first action step in support of that objective is to develop “a website that will provide South Dakotans with suicide prevention resources.” That website will be the first avenue for developing and disseminating the contents of the Toolkit. As prevention efforts build community by community throughout the state, Toolkit components will be modified or developed in response to the specific needs of people in South Dakota. Both the Toolkit and the SDSSP itself are “live” documents and must be continually reviewed, revised, and expanded to be of maximum benefit to community leaders and stakeholders in their quest to make successful suicide prevention a reality.

CONCLUSION

The South Dakota Strategy for Suicide Prevention is an extension of the National Strategy for Suicide Prevention. It is based directly on the framework of the NSSP and reflects the principles established by the National Strategy for effective suicide prevention. The SDSSP is intended to serve as a practical guide for individuals, groups, communities, and organizations as they address suicide prevention and aftercare in South Dakota.

To be effective, the SDSSP must evolve according to the needs of South Dakota’s people and communities. In addition, the ongoing development of the SDSSP must take into account the fact that suicide prevention is a rapidly expanding field, and new ideas, research, and programs are

constantly being incorporated into prevention initiatives throughout the country. The SDSSP is a starting point, a reference, and a guideline for dedicated people as they work to reduce suicide attempts and completions throughout South Dakota. It is well-established that suicide is preventable, and by working together with the SDSSP as the blueprint, South Dakotans can design and implement activities that will save lives.

The task ahead presents a great challenge. The hope is that this strategy will provide the foundation, the inspiration, and the knowledge for reducing suicide in South Dakota. It is time for people across the state to advance the discussion—in families, schools, and neighborhoods—about the tragedy of suicide and what each person can do to stop it. Suicide prevention is truly everyone's business, and everyone in South Dakota can make a difference.

GOALS, OBJECTIVES, ACTION STEPS

The SDSSP Workgroup designed the goals and objectives of the South Dakota Strategy for Suicide Prevention to be the framework for a public health response to suicide throughout the state. The action steps below are examples of the type of initiatives that should be considered in implementing the strategy. Considerations in formulating the action steps included their feasibility, their necessity as part of the foundation for a statewide effort, the impact they might have on suicide prevention, and the possibility that they might be funded by public or private sources that support suicide prevention. The Workgroup outlined one or two examples of possible action steps for each objective, but the action steps presented below represent only a point of departure. This is a work in progress: Priorities must be set among the action steps, each one must build upon the one that precedes it, and all are subject to change according to the dictates of overall prevention efforts in the state.

GOAL 1: Maintain a South Dakota Community Toolkit for Suicide Prevention that guides the development and implementation of suicide prevention programs and training. (See page 33.)

Objective 1.1: Maintain a centralized clearinghouse to coordinate and enhance suicide prevention efforts at the state and community level.

RECOMMENDED ACTION STEP: Establish a website to provide South Dakotans with effective suicide prevention resources.

1.2—Implement effective, research-based suicide prevention programs to reach the public and at-risk populations, such as the elderly, Native Americans, youth and young adults, and rural communities.

RECOMMENDED ACTION STEP: Create a Toolkit component that outlines cultural distinctions among prevention programs and how they are implemented in various populations, specifically with rural and Native American people.

1.3—Integrate suicide prevention programs throughout communities in settings such as primary care, emergency medical care, mental health care, substance abuse treatment, faith communities, elderly and long-term care, correctional facilities, and social services programs.

RECOMMENDED ACTION STEP: Create as a Toolkit component a concise multi-media presentation on suicide assessment, treatment, and referral for family practice physicians and nurses throughout South Dakota.

1.4—Provide schools with guidelines to develop effective suicide prevention programs.

RECOMMENDED ACTION STEP: Survey all school districts in South Dakota on their current suicide prevention programs using an instrument such as the “Information Dissemination in Schools Checklist” from the Youth Suicide Prevention School-Based Guide,⁶¹ and use the collected information as a starting point to develop effective statewide policies on suicide prevention in schools.

1.5—Increase the proportion of suicide prevention gatekeepers who recognize at-risk behavior and respond appropriately.

RECOMMENDED ACTION STEP: Create as a Toolkit component a database of presentation and training resources on suicide prevention, such as public speakers and certified gatekeeper trainers.

GOAL 2: Promote strategies to educate the public as well as community and industry leaders that suicide is a public health problem that is preventable.

2.1—Develop public information campaigns designed to increase public knowledge of suicide prevention.

1ST RECOMMENDED ACTION STEP: Work with the South Dakota Newspaper Association to create public service advertisements on the common signs and symptoms of suicidal behavior.

2ND RECOMMENDED ACTION STEP: Create a standardized presentation on youth suicide prevention for parents, teachers, and other groups in South Dakota that interact regularly with young people.

61. Doan, J., Lazear, K., & Roggenbaum, S. “Checklist 1: Information Dissemination in Schools” in *Youth Suicide Prevention School-Based Guide*. Tampa, Fla.: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida, 2003. Available at http://cfs.fmhi.usf.edu/StateandLocal/suicide_prevention.

2.2—Develop suicide awareness presentations that educate leaders and policy makers on the need for suicide prevention policy and funding.

RECOMMENDED ACTION STEP: Distribute to all South Dakota city-, county-, and tribal-level officials a packet of information explaining their role in the implementation of the SDSSP.

GOAL 3: Develop and promote effective clinical and professional practices.

Objective 3.1—Provide licensed professionals with evidence-based suicide risk screening and assessment tools that are setting and culture specific.

1ST RECOMMENDED ACTION STEP: Develop and disseminate a resource guide of evidence-based suicide risk screening and assessment tools for use by licensed professionals.

2ND RECOMMENDED ACTION STEP: Partner with state-level organizations, such as the South Dakota chapter of the National Alliance for the Mentally Ill, to provide an orientation to the screening and assessment resource guide at annual conferences and through other statewide avenues.

3.2—Work with licensing and certification bodies to standardize suicide prevention and treatment training for doctors, nurses, psychologists, mental health counselors, social workers, chemical dependency counselors, school staff, QMHP-certified practitioners, and other professional caregivers.

RECOMMENDED ACTION STEP: Hold a joint meeting with representatives of the licensing and certification bodies in South Dakota to explore how to improve suicide prevention training and continuing education in their disciplines.

3.3—Work with postsecondary schools to develop effective clinical and professional education on suicide.

RECOMMENDED ACTION STEP: Through interviews, catalog the offerings on effective clinical and professional education on suicide that are now available in South Dakota postsecondary schools.

3.4—Develop effective case management systems for advancing treatment through and across all levels of care.

RECOMMENDED ACTION STEP: Design and test a model for improved follow-up care in South Dakota for patients admitted for suicide ideation or an attempt after they are discharged from a hospital to a community setting.

GOAL 4: Improve access to and community linkages among primary care, mental health, and substance abuse services.

Objective 4.1—Increase mental health, substance abuse, and primary care collaboration and cross-training.

RECOMMENDED ACTION STEP: Work with Community Mental Health Centers, Division of Alcohol and Drug Abuse programs, and major primary healthcare providers in South Dakota to assess the strengths and weaknesses of their collaborative efforts.

4.2—Assure that schools have effective linkages with mental health and substance abuse services.

RECOMMENDED ACTION STEP: Provide training to school personnel in South Dakota designed to reduce the stigma associated with mental illness and substance abuse, and include information on sources of help available in the community.

4.3—Improve the effectiveness of first responders in addressing mental health and substance abuse issues.

RECOMMENDED ACTION STEP: Work with law enforcement statewide to assess the strengths and weaknesses of South Dakota law officers' responses to situations involving mental health and substance abuse issues.

GOAL 5: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the media.

Objective 5.1—Promote accuracy, sensitivity, and responsibility in news coverage of mental illness, substance abuse, suicidal behavior, and the effects of suicide.

RECOMMENDED ACTION STEP: Form a partnership with the South Dakota media industry to develop guidelines for news coverage of mental illness, suicidal behavior, and the effects of suicide.

5.2—Promote accuracy, sensitivity, and responsibility in entertainment and other media presentations of mental illness, substance abuse, suicidal behavior, and the effects of suicide.

RECOMMENDED ACTION STEP: Create an informational package for parents on the effects that media depictions of mental illness, substance abuse, and suicidal behavior might have on youth.

5.3—Work with schools and universities to develop curricula for journalism and related courses on how to report on stories involving mental illness, substance abuse, suicidal behavior, and the effects of suicide.

RECOMMENDED ACTION STEP: Provide the guidelines “Reporting on Suicide: Recommendations to the Media” to journalism and other educators and request that they include instruction on the guidelines in their courses.

GOAL 6: Reduce the danger of lethal means and methods of self-harm.

Objective 6.1—Engage with stakeholders to develop safety messages about lethal means.

RECOMMENDED ACTION STEP: Work with South Dakota sportsmen’s groups to develop and disseminate to their membership a safety message about firearms and suicide.

6.2—Use public information campaigns to disseminate safety messages designed to reduce the danger of lethal means and methods of self-harm.

RECOMMENDED ACTION STEP: Work with the South Dakota Pharmacists Association and other stakeholders to develop and disseminate public information messages about preventing intentional overdoses with prescription and nonprescription medicine.

GOAL 7: Improve and expand surveillance systems.

Objective 7.1—Publish an annual public report on suicide deaths and attempts designed to improve the public health response to suicide and based on sources such as health data, psychological autopsies, and demographic and epidemiological information.

RECOMMENDED ACTION STEP: Have the leadership team from the SDSSP Workgroup (representatives from the S.D. Departments of Health and Human Services, the HELP!Line Center, and the Front Porch Coalition) create a strategy for identifying and gathering the necessary information and for creating and disseminating the report.

7.2—Increase the proportion of health professionals who collect uniform and reliable data on suicidal behavior by coding external causes of injury based on the International Classification of Diseases.

RECOMMENDED ACTION STEP: Work with South Dakota health professionals to improve the reporting of information related to suicide attempts, based on the International Classification of Diseases.

7.3—Develop and refine standardized protocols for death scene investigations.

RECOMMENDED ACTION STEP: Work with the S.D. Attorney General's Office and the S.D. Department of Health to assess death-scene investigation policies and procedures in South Dakota, specifically regarding the collection of useful data for preventing intentional and unintentional injuries.

GOAL 8: Improve services to people who have been affected by the death of a loved one by suicide.

Objective 8.1—Implement guidelines for caregivers for effectively responding to the unique needs of survivors of suicide.

RECOMMENDED ACTION STEP: Develop and disseminate a basic fact sheet for South Dakota caregivers on helping survivors of suicide.

8.2—Implement effective, comprehensive support programs for survivors of suicide.

RECOMMENDED ACTION STEP: Hold a statewide conference in South Dakota for suicide survivors, designed to provide education and support and to assess their needs for services.

APPENDIX A



SOUTH DAKOTA SENATE

Seventy-Eighth Legislative Session

Arnold M. Brown
President Pro Tempore

Dennis Daugaard
President

Patricia Adam
Secretary

SENATE CONCURRENT RESOLUTION NO. 5

A CONCURRENT RESOLUTION, Supporting the creation of a South Dakota plan for suicide prevention.

WHEREAS, suicide is consistently among the top ten leading causes of death in South Dakota. In recent years suicide has been the second leading cause of death in South Dakota for youth and young adults between the ages of fifteen through thirty-four. Indeed, suicide is the cause of death for about one hundred people every year in South Dakota; and

WHEREAS, between two and three thousand suicide attempts occur annually in South Dakota, resulting in hundreds of serious or disabling physical injuries and in mental and emotional stress to individuals as well as in emotional trauma and hardship to their families; and

WHEREAS, each suicide drastically affects numerous family members, friends, and colleagues who must grieve the death of a loved one, a grief that is debilitating for many people. There are approximately forty thousand people in South Dakota who have had a loss to suicide interrupt their lives; and

WHEREAS, the suicide death rate per one hundred thousand people in South Dakota is about one-and-a-half times the rate of suicide in the United States, on average. The suicide death rate for people, ages fifteen to twenty-four, in South Dakota is twice the rate of suicide in the United States; and

WHEREAS, the suicide completion rate is very high for young people in South Dakota and extremely high for elderly white men and young Native American men; and

WHEREAS, the stigma associated with mental illness deters suicide prevention by keeping people at risk of completing suicide from seeking lifesaving help; and

State Capitol, 500 East Capitol, Pierre, SD 57501-5070
605/773-3825 (Senate Secretary); 773-3821 (Senate Lobby)
South Dakota Legislature's Home page : <http://legis.state.sd.us>

WHEREAS, the stigma associated with suicide deaths seriously inhibits surviving family members from regaining healthy lives and a sense of meaning in life; and

WHEREAS, suicide deaths impose an enormous unrecognized and unmeasured economic burden on South Dakota in terms of potential years of life lost and medical costs and in terms of decreasing the capacity of mourners to contribute to their work, their families, and their communities; and

WHEREAS, the causes of suicide are complex and multifaceted, involving biological, sociological, psychological, and societal factors; and

WHEREAS, even though the link between mental illness and suicide is well established and many suicides are preventable, there is still an urgent and ongoing need for the development of effective mental-health promotion and suicide prevention programs; and

WHEREAS, the opportunity is present now for a comprehensive, research-based response to suicide prevention because of recent and ongoing advances in clinical research, in the treatment of mental disorders, in basic neuroscience, and in the development of community-based initiatives for prevention; and

WHEREAS, suicide prevention efforts should be encouraged and supported to the greatest extent possible:

NOW, THEREFORE, BE IT RESOLVED, by the Senate of the Seventy-eighth Legislature of the State of South Dakota, the House of Representatives concurring therein, that the Legislature of the State of South Dakota recognizes that suicide is a significant problem in the state, and declares the prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem to be a state priority; and

BE IT FURTHER RESOLVED, that the Legislature acknowledges that no single suicide prevention program or effort will be appropriate for all populations or communities; and

BE IT FURTHER RESOLVED, that the Legislature encourages the development and the promotion of accessibility and affordability of mental health services enabling all persons at risk for suicide to obtain effective services without fear of stigma; and


BE IT FURTHER RESOLVED, that the Legislature encourages the development of evidence-based initiatives dedicated to preventing suicide, to responding to those at risk for suicide and who

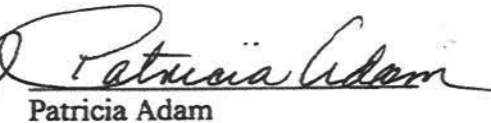
have attempted suicide, and to supporting people who have lost someone to suicide; and

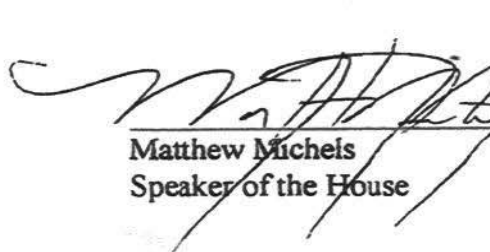
BE IT FURTHER RESOLVED, that the Legislature supports the creation of a South Dakota plan for suicide prevention that will lay the groundwork for suicide prevention efforts that are designed specifically for use in South Dakota communities and based on the principles outlined in the national strategy for suicide prevention.

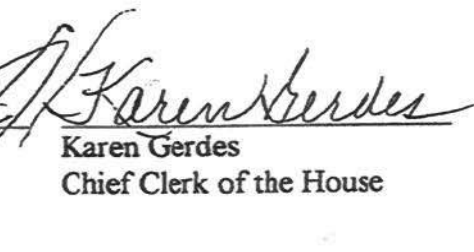
Adopted by the Senate,
Concurred in by the House of Representatives,

February 13, 2003
February 24, 2003


Dennis Daugaard
President of the Senate


Patricia Adam
Secretary of the Senate


Matthew Michels
Speaker of the House


Karen Gerdes
Chief Clerk of the House

APPENDIX B:

SUICIDE PREVENTION DICTIONARY⁶²

Activities — the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Adolescence — the period of physical and psychological development from the onset of puberty to maturity.

Advocacy groups — organizations that work in a variety of ways to foster change with respect to a societal issue.

Affective disorders — see mood disorders.

Anxiety disorder — an unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Best practices — activities or programs that are in keeping with the best available evidence regarding what is effective.

Biopsychosocial approach — an approach to suicide prevention that focuses on those biological, psychological and social factors that may be causes, correlates, and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder — a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Causal factor — a condition that alone is sufficient to produce a disorder.

Cognitive/cognition — the general ability to organize, process, and recall information.

Community — a group of people residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans — plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Comorbidity — the co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

62. *NSSP*, 196–204.

Connectedness — closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer — a person using or having used a health service.

Contagion — a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate — a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture — the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Depression — a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective — prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Environmental approach — an approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology — the study of statistics and trends in health and disease across communities.

Evaluation — the systematic investigation of the value and impact of an intervention or program.

Evidence-based — programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study — the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Frequency — the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors which can repeat over time.

Gatekeepers — those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal — a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health — the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health and safety officials — law enforcement officers, fire fighters, emergency medical technicians (EMT's), and outreach workers in community health programs.

Healthy People 2010 — the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Indicated prevention intervention — intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intentional — injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention — a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means — the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Means restriction — techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods — actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Mental disorder — a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health — the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

Mental health problem — diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Mental health services — health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness — see mental disorder.

Mood disorders — a term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states; included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Morbidity— the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality — the relative frequency of death, or the death rate, in a community or population.

Objective — a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

Outcome — a measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs — programs that send staff into communities to deliver services or recruit participants.

Personality disorders — a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Postvention — a strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention — a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors — factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Psychiatric disorder — see mental disorder.

Psychiatry — the medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychology — the science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Public information campaigns — large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate — the number per unit of the population with a particular characteristic, for a given unit of time.

Residency programs — postgraduate clinical training programs in special subject areas, such as medicine.

Resilience — capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors — those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening — administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools — those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention — intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm — the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Self-injury — see self-harm.

Sociocultural approach — an approach to suicide prevention that attempts to affect the society at large, or particular subcultures within it, to reduce the likelihood of suicide (such as adult-youth mentoring programs designed to improve the well-being of youth).

Social services — organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support — assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Specialty treatment centers (e.g., mental health/substance abuse) — health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

Stakeholders — entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations and policies.

Stigma — an object, idea, or label associated with disgrace or reproach.

Substance abuse — a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) — a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior — a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation — self-reported thoughts of engaging in suicide-related behavior.

Suicidality — a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide — death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt — a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors — individuals who have survived a prior suicide attempt.

Suicide survivors — family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance — the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Unintentional — term used for an injury that is unplanned; in many settings these are termed accidental injuries.

Universal preventive intervention — intervention targeted to a defined population, regardless of risk; (this could be an entire school, for example, and not the general population per se).

APPENDIX C: RESOURCES

NATIONAL

American Association of Suicidology (AAS)
4201 Connecticut Avenue N.W., Suite 408
Washington, DC 20008
Phone: 202-237-2280
Fax: 202-237-2282
<http://www.suicidology.org>

American Foundation for Suicide Prevention (AFSP)
120 Wall Street, 22nd Floor
New York, NY 10005
Toll-Free: 888-333-AFSP
Phone: 212-363-3500
Fax: 212-363-6237
E-mail: inquiry@afsp.org
<http://www.afsp.org>

Suicide Prevention Action Network (SPAN USA)
1025 Vermont Avenue N.W., Suite 1200
Washington, DC 20005
Phone: 202-449-3600
Fax: 202-449-3601
<http://www.spanusa.org>

Suicide Prevention Resource Center (SPRC)
Education Development Center
55 Chapel Street
Newton, MA 02458
Toll-free: 877-GET-SPRC (438-7772)
E-mail: info@sprc.org
<http://www.sprc.org>

U.S. Centers for Disease Control and Prevention (CDC)
<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>
<http://www.cdc.gov/ncipc/wisqars>

National Institute of Mental Health (NIMH)
<http://www.nimh.nih.gov/publicat/harmaway.cfm>
<http://www.nimh.nih.gov/suicideprevention/suicidefaq.cfm>

SOUTH DAKOTA

S.D. Department of Health
600 East Capitol Avenue
Pierre, SD 57501
Toll-free: 800-738-2301 (inside S.D.)
Phone: 605-773-3361
Fax: 605-773-5942
<http://www.state.sd.us/doh/suicide>

S.D. Department of Human Services
East Highway 34, Hillsvie Plaza
c/o 500 East Capitol Avenue
Pierre, SD 57501
Phone: 605-773-5990
Fax: 605-773-5483
<http://www.state.sd.us/dhs>

Front Porch Coalition
521 Kansas City Street, #2
Rapid City, SD 57701
Phone: 605-348-6692
<http://www.frontporchcoalition.org>

HELP!Line Center
1000 N. West Avenue, Suite 310
Sioux Falls, SD 57104
Phone: 605-339-4357
<http://www.helplinecenter.org>

BIBLIOGRAPHY OF PRINT MATERIALS

The American Association of Suicidology maintains an up-to-date bibliography of suicide prevention and related topics at
http://www.suicidology.org/associations/1045/files/notable_refs.cfm.

ESSENTIAL SOURCES: SUICIDE PREVENTION AND PUBLIC HEALTH

National Strategy for Suicide Prevention
<http://www.mentalhealth.org/suicideprevention/default.asp>
<http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

Reducing Suicide: A National Imperative (Institute of Medicine)
<http://www.nap.edu/books/0309083214/html>

Report of the President's New Freedom Commission on Mental Health
<http://www.mentalhealthcommission.gov/reports/reports.htm>